Lilly Cares

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Lilly Cares Prescription FAX Form Humatrope®

Patient Name: ____ **Date of Birth:** ____________________________________

Address: ____ **Telephone Number:** ______________________________

Rx: I authorize Lilly Cares to act on my behalf for the purpose of transmitting this prescription to the appropriate pharmacy.

□ **HumatroPen® Injection Device** *(select one)* □ **6 mg** NDC 0002956001 □ **12 mg** NDC 0002956101 □ **24 mg** NDC 0002956201

A device prescription is needed with the initial dosing prescription. Patients are limited to one pen per year, unless the dosage changes and a new pen size is needed to fit the new cartridge size.

□ **Humatrope® Cartridge** *(select one)*

□ **6 mg** cartridge kit (gold) NDC 00028147 □ **12 mg** cartridge kit (teal) NDC 0002814801 □ **24 mg** cartridge kit (purple) NDC 0002814901

Quantity to Dispense:______________month supply *(max 4 mos.)* Refills: #________________

□ **Pen needles** (*not included with Injection Device*): □ BD™ Pen Needles 31G X 5/16" (8 mm) □ BD™ Nano™ Needles 32G X 5/32" (4 mm)

□ **Humatrope® Vial Kit**: Humatrope® 5 mg vial with 5 mL vial diluent for Humatrope® NDC 0002733511

Quantity to Dispense:______________month supply *(max 4 mos.)* Refills: #________________

□ Reconstitution syringes: BD™ Luer Lok 21G or 22G X 1" 3 mL

□ Administration syringes *(select one)*: □ Adult: BD™ Insulin 31G X 5/16" 1 mL □ Pediatric: BD™ Insulin 31G X 5/16" 0.5 mL

□ Sterile water diluent 5 mL vials #________vials *(for patients allergic to diluent in kit)*

SIG/Directions:____ Date: _________________________

Your state may require that prescriptions follow certain content requirements or use a particular form. By signing below you certify that you are abiding by laws applicable to prescriptions and authorized prescribers in the states in which you are prescribing.

Signature: ____ ____

Dispense as written **Substitution/brand exchange permitted**

Supervising Physician Signature and Date *(where required)*: ____

Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.

Printed Prescriber Name and Title: ____

Prescriber State License # and State: __________________ DEA #_________________(as required) Telephone: ___________________

Prescriber Address: ____ Prescriber FAX: ____________________

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